WESTSIDE Gastroenterology ASSOCIATES
3825 Medical Park Drive SW
Suite 300
Austell, GA 30106-1109
Phone: (770) 941-4810
Fax: (770) 948-9149

COVID-19 Patient Screening Form

Today's Date:_____

Name:_____
FIRST MIDDLE LAST FORMER LAST (IF CHANGED)

Date of Birth:_____ **Temperature:** _____

We are screening all patients for signs and symptoms of COVID-19 ("coronavirus") to protect our patients and staff. We are requesting that you wear a face mask to your appointment and that you come alone unless you require assistance.

Please answer the following questions:

1. Do you have a fever of 100.4 °F or higher? ☐YES ☐NO
2. Do you have a new or worsening cough, shortness of breath, runny nose, nasal congestion, loss of taste or smell, sore throat, painful swallowing, headache, muscle aches, fatigue, chills, loss of appetite, vomiting or diarrhea? ☐YES ☐NO
3. Have you been instructed in the last 14 days to self-isolate for any of the following reasons?
   - Travel outside of the US in the last 14 days? ☐YES ☐NO
   - Contact with someone known to have COVID-19 in the last 14 days? ☐YES ☐NO
   - Have been tested for COVID-19 and are waiting for results? ☐YES ☐NO

I have filled out this form to the best of my abilities as accurately as possible.

Patient/Guarantor Signature:_____

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Jasmine G. Jeffers, M.D.

PATIENT DATA

FORM MUST BE COMPLETED IN FULL

PATIENT INFORMATION

Today's Date:_____

Name:_____
FIRST MIDDLE LAST FORMER LAST (IF CHANGED)

Address:_____
STREET APARTMENT/UNIT # CITY STATE ZIP

Phone:_____
CELL HOME WORK

Primary Phone is: ☐ Cell ☐ Home ☐ Work **Email Address:**_____

DOB:_____ **Age:**_____ **Last 4 digits of SSN#:** ___ ___ ___ ___

Marital Status	Race	Ethnicity	Sex
☐ Married	☐ Alaskan Native/Native American ☐ Asian	☐ Hispanic or Latino	☐ Male
☐ Single	☐ Black/African American	☐ Non-Hispanic or Latino	☐ Female
☐ Divorced	☐ Native Hawaiian/Other Pacific Islander ☐ Other	☐ Declined	
☐ Widowed	☐ White ☐ Unknown ☐ Declined		

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Employer: Name:_____ Occupation:_____ Phone:_____

Address:_____
STREET CITY STATE ZIP

Referred by: Name:_____ Phone:_____ Fax: _____

Primary Care Provider: Name:_____ Phone:_____ Fax:_____

INSURANCE INFORMATION

Primary:_____ Policy#:_____ Group#:_____

Name of Insured & Relationship:_____ DOB:_____

Secondary:_____ Policy#:_____ Group#:_____

Name of Insured & Relationship:_____ DOB:_____

COMPLETE THE SECTION BELOW IF YOU ARE *NOT* THE POLICY HOLDER

Name:_____ **DOB:**_____ **Phone:**_____ **Relationship:**_____

Address:_____ **SSN#:**_____

EMERGENCY CONTACT

Spouse, companion, relative or friend living with you:

Name:_____ Relationship:_____ Phone:_____

Nearest friend or relative NOT living with you:

Name:_____ Relationship:_____ Phone:_____

I have filled out this form to the best of my abilities as accurately as possible.

Patient/Guarantor Signature:_____ Date:_____

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

RIGHT TO INSPECT & COPY. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept ai this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

RIGHT TO AN ACCOUNTING OF DISCLOSURES WE HAVE MADE. You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center.

The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

RIGHT TO REQUEST AN ALTERNATIVE METHOD OF CONTACT. You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative form of contact, you must provide us with a request in writing. You may write us a letter of fill out an Alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

RIGHT TO NOTIFICATION IF A BREACH OF YOUR MEDICAL INFORMATION OCCURS. You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information:

- ⇒ A brief description of what happened;
- ⇒ A description of the health information that was involved;
- ⇒ Recommended steps you can take to protect yourself from harm;
- ⇒ What steps we are taking in response to the breach; and,
- ⇒ Contact procedures so you can obtain further information.

RIGHT TO OPT-OUT OF FUNDRAISING COMMUNICATIONS. If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

RIGHT TO A PAPER COPY OF THIS NOTICE. You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

CHANGES TO THIS NOTICE. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the bottom right corner of the first page.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Privacy Officer: Devon Spencer
Effective Date: May 28, 2014 **REV: 07/2024**

WHO WILL FOLLOW THIS NOTICE. Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

HOW WE MAY USE & DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment. We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations. We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Persons Involved in Your Care. We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: it the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

Required by Law. We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services, We will comply with those state laws and with all other applicable laws.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

NATIONAL PRIORITY USES AND DISCLOSURES MADE WITHOUT YOUR CONSENT OR AUTHORIZATION. When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

National Priority Uses and Disclosures Made Without Your Consent or Authorization. When permitted by law. we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:

- ⇒ Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
- ⇒ Threat to health or safety, such as to avert or lessen a serious threat;
- ⇒ Workers' compensation or similar programs, such as for the processing of claims;
- ⇒ Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim or abuse;
- ⇒ Health oversight activities, such as to a government agency to investigate possible insurance fraud;
- ⇒ Court or legal proceedings, such as if a judge orders us to do so;
- ⇒ Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
- ⇒ Coroner or medical examiner for identification of a body;
- ⇒ Public health activities, such as required by the US Food and Drug Administration (FDA); and,
- ⇒ Certain government functions, such as using or disclosing for government functions like military and veterans' activities and national security and intelligence activities.

USES & DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION. The following uses and disclosures of medical information about you will only be made with your authorization (signed permission) from you or your personal representative:

- ⇒ Uses and disclosures for marketing purposes.
- ⇒ Uses and disclosures that constitute the sales of medical information about you.
- ⇒ Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
- ⇒ Any other uses and disclosures not described in this Notice.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION.

Complaints. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address:

3825 Medical Park Drive SW
Suite 300
Austell, Georgia 30106

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775
Website: http://www.hns.gov/ocr/privacy/hipaa/complaints/index.html
Email: OCRComplaint@hhs.gov

RIGHT TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES. You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and,
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restrictions(s).

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

FORM MUST BE COMPLETED IN FULL

Patient Name:_____ **DOB:** _____

When you visit Westside Gastroenterology Associates, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. Westside Gastroenterology Associates has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that Westside Gastroenterology Associates provide all of our patients with the Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

I acknowledge that I have received a copy of the Westside Gastroenterology Associates' Notice of Privacy Practices and have been given an opportunity to ask questions.

_____ _____
PATIENT SIGNATURE DATE OF RECEIPT

_____ _____
PRINT NAME OF AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE OF AUTHORIZED PERSONAL REPRESENTATIVE

_____
PLEASE INDICATE RELATIONSHIP TO PATIENT

HOW MAY WE CONTACT YOU?

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. ***Westside Gastroenterology Associates may notify me about my results or protected health information by the following contact methods*:**

Cell phone:		Home telephone:		Voice Mail/Answering machine:		Work Phone:		Email:	
☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO	☐ YES	☐ NO

May we fax medical records for referrals?

☐ YES	☐ NO

***If you cannot be reached, please list names of people with whom we can discuss your medical care*:**

_____ _____
NAME & RELATIONSHIP PHONE

_____ _____
NAME & RELATIONSHIP PHONE

I authorize Westside Gastroenterology Associates to leave medical information pertaining to my care by the above methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

_____ _____
PATIENT/AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE TODAY'S DATE

Please list a "unique identifier" as a way to confirm your identity when receiving or making calls to and/or from the office. This "unique identifier" must be given before any information can be disclosed. This can be the last four digits of your social security or mother's maiden name.

Unique Identifier: _____

FOR USE BY WESTSIDE GASTROENTEROLOGY ASSOC. PERSONNEL ONLY: (Complete if Patient Acknowledgment is not obtained.)

An acknowledgment of Receipt of Notice of Privacy Practices was not obtained because:

☐ Patient refused to sign Acknowledgment.

☐ Unable to gain signed Acknowledgment due to communication/ language or other barrier.

☐ Patient was unable to sign Acknowledgment due to emergency treatment situation.

☐ Other: Indicate reason_____

Signature of WESTSIDE GASTROENTEROLOGY ASSOCIATES Representative: _____

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CONSENT & RELEASE

FORM MUST BE COMPLETED IN FULL

Patient Name:_____ **DOB:**_____

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

1. The patient or legal custodian has authorized the Staff Physician(s) or Nurse Practitioner(s) to examine and treat the above patient.
2. Westside Gastroenterology is granted permission to release any information deemed necessary, as may be requested, relating to any treatment rendered to patient, to the insurance carriers, referring physician and primary care physician.
3. The patient or legal custodian shall agree to pay to Westside Gastroenterology such sums as are, or may become, due for services rendered to the patient.
4. ALL COPAYS AND DEDUCTIBLE ARE DUE AT THE TIME OF SERVICE INCLUDING ANY OUTSTANDING BALANCES.
5. In the event that the patient's insurance company does not make full payment on this obligation, all balances will be due and immediately payable by the patient and/or legal custodian.
6. A returned check fee of $30 will be assessed on any and all returned checks.
7. Delinquent accounts will be assessed all collection, legal, and administrative costs to the fullest extent of the law.
8. Patient or legal custodian understands that if their insurance company requires that a referral be issued, it must be received at time of service. If seen without a valid referral the patient accepts responsibility for full payment at the time of service with understanding that no claim will be filed with the insurance carrier.

Our fees for surgical procedures will vary depending on the service provided. We will ask for the patient's portion of the surgical bill at the time of the surgery (outstanding deductible and/or copay). You will receive separate bills from the surgery facility, lab, etc.

INSURANCE PAYMENT PLAN

We will file insurance with your provider according to your individual plan. The patient will be responsible for any outstanding deductible, their % and/or co-pay. Referral numbers required by some insurance companies must be given at the time of service, otherwise the service becomes the patient's responsibility. For all private insurance companies, the patient will be responsible for payment at time of service. We will provide the necessary information for the patient to file for reimbursement.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, otherwise payable to me for services as described, realizing that I am responsible to pay non-covered services.

_____

PATIENT/AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE TODAY'S DATE

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims

_____

PATIENT/AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE TODAY'S DATE

PLEASE INITIAL EACH LINE ACKNOWLEDGING THAT YOU HAVE READ AND WILL COMPLY WITH OUR OFFICE POLICIES.

_____All fees including copays, coinsurance, deductibles, and balances are due at the time of service.

_____ It is the patient's responsibility to notify the office of any changes to your insurance, address, or contact information.

_____ If refills are needed, an appointment is required. Please do not wait until you are out of medication.

_____ Messages left for the provider and /or nurses will be addressed and returned within 48 hours.

_____ Test results including: labs, pathology, radiology, stool studies etc. require at least 3-4 business days to be obtained and released by the provider.

_____ Cancellations are to be made at least 24 hours prior to your scheduled appointment time. If not, patient accepts full responsibility to pay $50 cancellation fee.

_____ If the physician determines that the patient's "flex sig" preparation is incomplete, patient is subject to pay a $75 fee.

_____

PATIENT/AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE TODAY'S DATE

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

FORM MUST BE COMPLETED IN FULL

Name:_____
FIRST MIDDLE LAST FORMER LAST (IF CHANGED)

DOB:_____ **SSN#:** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

I request and authorize _____
to release healthcare information of the patient named above to:

Name: ***WESTSIDE GASTROENTEROLOGY ASSOCIATES***
Address: ***3825 MEDICAL PARK DRIVE, SUITE 300***
City: ***AUSTELL*** State: ***GA*** Zip Code: ***30106***

This request and authorization applies to:

□ **Healthcare information relating to the following treatment, condition, or dates:**_____

_____

_____

□ **All healthcare information**

□ **Other:**_____

_____

HIPPA does not require consent or authorization for disclosure of protected health information (PHI) for the purpose of treatment by any health care provider. HIPPA allows providers to use or disclose PHI in consulting with other providers about the individual's treatment, without the patient's specific permission. Under HIPPA, a provider may share PHI without the patient's authorization for its own payment purposes including to insurers, third party administrators, self-funded insurance plans, collection agencies and credit reporting agencies. In addition, a provider may disclose PHI to another provider so that the other provider may be paid (for example, to a laboratory that needs insurance information so that it can be paid for the services it provided to the patient under the physician's orders.) However, under **Georgia** law, a provider is required to obtain a patient's consent to release medical records to others, including other physicians. If you receive a request to transfer medical records, you will need the patient's specific consent to do so.

_____
PATIENT/AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE TODAY'S DATE

REV: 07/2024

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PATIENT PORTAL INFORMED CONSENT

FORM MUST BE COMPLETED IN FULL

Name: _____
FIRST MIDDLE LAST FORMER LAST (IF CHANGED)

DOB: _____ **Email:** _____

PURPOSE OF THIS FORM

Westside Gastroenterology Associates offers secure viewing of parts of your medical record and communication from our staff as a service to our patients. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation. This service is optional and not necessary to interact and communicate with our clinic.

HOW THE SECURE PATIENT PORTAL WORKS

A secure Web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the correct password to log into the portal site.

HOW TO PARTICIPATE IN OUR PATIENT PORTAL

You can pick up secure messages or view information sent to you through a website. Once this form is agreed to and signed, we will send you an e-mail notification that guides you on how to register for the first time. This notification will give you the URL (internet address) of the website where you can log in using the username and password provided. Next you will be able to look in your message box and see any new or old messages or view other parts of your electronic medical record. You can read or view information on your computer, but it is still encrypted in transmission between the website and your computer. You can access the Patient Portal through our clinic web page: www.westsidegastro.com

PROTECTING YOUR PRIVATE HEALTH INFORMATION AND RISKS

This encrypted method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. When you pick up secure messages from the portal, you need to keep unauthorized individuals from learning your password and gaining access to your account. If you think someone has learned your password, you should promptly go to the website and change it. You need to make sure we have your correct e-mail address and are informed if it ever changes. We understand the importance of privacy in regards to your health care and will continue to strive to make all information as confidential as possible and will never sell or give away any private information, including e-mail addresses.

CONDITIONS OF PARTICIPATING IN THE PATIENT PORTAL

Access to the secure web portal is an optional service, and we may suspend or terminate it at any time and for any reason. If we do suspend or terminate the service we will notify you as promptly as we reasonably can. The patient agrees to not hold Westside Gastroenterology Associates or any of its staff liable for network infractions beyond their control.

_____
PATIENT/AUTHORIZED PERSONAL REPRESENTATIVE SIGNATURE TODAY'S DATE

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Jasmine G. Jeffers, M.D.

HEALTH HISTORY

FORM MUST BE COMPLETED IN FULL

Today's Date:_____

Name:_____ **DOB:**_____ **Age:**_____

Referred by: _____ **Phone:**_____

Primary Care Physician:_____ **Phone:** _____

For use by WESTSIDE GASTROENTEROLOGY ASSOCIATES:

Height:____' ____" **Weight:**_____ lbs. **Vital Signs:**_____ **Temp:**_____ **BP:**_____ **HR:**_____ **RR:**_____

Describe the reason(s) for your visit below:

_____

_____

_____

Location:_____
Onset/Duration:_____
Type/Quality:_____
Exacerbate/Relieving:_____
Associated Symptoms:_____
Previous Workup:_____

Have you ever had a colonoscopy? ☐Yes ☐No

Date: _____ Where was it done?:_____

1. MEDICAL HISTORY – Check all that apply.

☐Anemia
☐Glaucoma
☐Lung disease/Asthma/COPD
☐Sleep apnea
☐Heart disease
☐Heart attack
☐Atrial fibrillation
☐GERD
☐Stomach/Intestinal Ulcers
☐Diverticulosis
☐Irritable bowel syndrome (IBS)
☐Crohn's disease or Ulcerative colitis
☐Colon Polyps
☐Pancreatitis
☐Hepatitis or Cirrhosis
☐Diabetes
☐Hypertension
☐High cholesterol
☐High blood pressure
☐Kidney disease
☐Thyroid disease
☐Cancer: Type_____ Date:_____
☐Liver disease or cirrhosis
☐Strokes
☐Seizures
☐HIV/AIDS
☐Enlarged prostate
☐Arthritis/Osteoarthritis
☐Blood clots/DVT/PE

Additional information: _____

_____

_____

_____

Name:_____ **DOB:**_____ **Today's Date:**_____

2. SURGICAL HISTORY – Check all that apply. List year and any comments.

☐ Transplant surgery_____	☐Hemorrhoidectomy_____	☐Stomach surgery _____
☐ Breast surgery _____	☐Hernia repair_____	☐Thyroid surgery_____
☐Colon surgery_____	☐Hysterectomy_____	☐Tonsillectomy_____
☐Gallbladder surgery_____	☐ Ovaries removed_____	☐C-Section _____
☐Heart surgery_____	☐ Joint replacement_____	☐Prostate surgery_____
☐Brain surgery _____	☐ Spinal surgery_____	☐Bariatric surgery _____

Additional information: _____

_____

_____

3. ALLERGIES – List <u>all</u> known allergies & reactions.

Medication allergies:_____

☐ No known

Food/Environmental allergies: _____

☐ No known

4. MEDICATIONS – List <u>ALL</u> current medications INCLUDING over-the-counter AND herbal medications.

Name	Strength	How often	Name	Strength	How often

Do you take vitamins/nutritional supplements? ☐ No

☐ Yes: _____

Are you currently taking any blood thinners? ☐No

☐Coumadin ☐Plavix ☐Warfarin ☐Xarelto ☐Other:_____

Are you currently taking any aspirins/NSAIDs? ☐No

☐Advil ☐Aleve ☐BC Powder ☐Goody's Powder ☐Ibuprofen ☐Naprosyn ☐Other: _____

5. HABITS – Check all that apply. List any additional information.

Provide some details regarding current and/or past use of the following:

Tobacco (cigarettes/cigars, etc.) ☐Never ☐Former: *Age started*_____ *Age stopped*_____ *# of packs/day*_____

☐Currently *(# of packs)*:_____ *Age started*_____ *Age stopped*_____ *most # packs/day*_____
PER DAY PER WEEK PER MONTH

Alcohol (beer, wine, liquor) ☐Never ☐Former ☐Currently (# of drinks):_____
PER DAY PER WEEK PER MONTH

Coffee/Tea ☐Never ☐Former ☐Currently (Every day) ☐Currently (Some days) ☐ Currently (Unknown)

I.V. or Recreational drugs ☐Never ☐Former ☐Currently (Every day) ☐Currently (Some days) ☐ Currently (Unknown)

Additional information: _____

_____

_____

_____

Name:_____ **DOB:**_____ **Today's Date:**_____

6. SOCIAL HISTORY

Are you: ☐Married ☐Divorced ☐Single ☐Widowed

Describe your profession:_____

What is your nationality?:_____

How many children do you have?:_____ ☐I don't have any children.

Additional information: _____

_____

_____

_____

7. FAMILY HISTORY – Check all that apply. (1st degree relatives only.)

	Mother	**Father**	**Brother**	**Sister**	**Daughter**	**Son**	Age at diagnosis (if known)
Colon polyps	☐	☐	☐	☐	☐	☐	_____
Crohn's disease	☐	☐	☐	☐	☐	☐	_____
Ulcerative Colitis	☐	☐	☐	☐	☐	☐	_____
Cancer							
Breast	☐	☐	☐	☐	☐	☐	_____
Colon	☐	☐	☐	☐	☐	☐	_____
Esophagus	☐	☐	☐	☐	☐	☐	_____
Lung	☐	☐	☐	☐	☐	☐	_____
Uterine, Bladder, or Ureter	☐	☐	☐	☐	☐	☐	_____
Pancreas	☐	☐	☐	☐	☐	☐	_____
Prostate	☐	☐	☐	☐	☐	☐	_____
Stomach	☐	☐	☐	☐	☐	☐	_____
Other:_____	☐	☐	☐	☐	☐	☐	_____
Gallstones	☐	☐	☐	☐	☐	☐	_____
Heart disease	☐	☐	☐	☐	☐	☐	_____
Liver disease	☐	☐	☐	☐	☐	☐	_____
Mental disease:_____	☐	☐	☐	☐	☐	☐	_____
Pancreatitis	☐	☐	☐	☐	☐	☐	_____
Stroke	☐	☐	☐	☐	☐	☐	_____
Tuberculosis	☐	☐	☐	☐	☐	☐	_____
Stomach ulcers	☐	☐	☐	☐	☐	☐	_____
Other: _____	☐	☐	☐	☐	☐	☐	_____

Additional information: _____

_____

_____

Name:_____ **DOB:**_____ **Today's Date:**_____

8. REVIEW OF SYMPTOMS – Are you experiencing any of the following? Check all that apply.

HEENT
- ☐Sore throat
- ☐Sinus/Postnasal drip
- ☐Hoarseness
- ☐Gum bleed
- ☐Tooth pain
- ☐Bad breath
- ☐Dentures/partials
- ☐Other:_____

OPHTHALMOLOGIC
- ☐Blurred vision
- ☐Glaucoma
- ☐Other:_____

PULMONARY
- ☐Shortness of breath
- ☐Chronic cough
- ☐Cough up blood
- ☐Asthma/wheezing
- ☐Sleep apnea
- ☐Shortness of breath

Last flu shot: _____
Last pneumonia vaccine:_____
- ☐Other:_____

CARDIAC
- ☐Chest pain
- ☐Palpitations
- ☐Swollen ankles
- ☐Short of breath lying down
- ☐History of heart attack
- ☐History of valve replacement
- ☐History of irregular heart

Last EKG: _____
- ☐Other: _____

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating/Flatulence
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Heartburn/Esophageal Reflux
- ☐ Rectal bleeding
- ☐ Belching
- ☐ Anal/Rectal itching or pain
- ☐ Bloody stools
- ☐ Pain in stomach
- ☐Diarrhea/Loose, Watery Stool

# of stools per day: _____
# of days per week:_____
- ☐Other: _____

GYN
- ☐ Lower abdominal pain
- ☐ Vaginal bleeding
- ☐ Irregular vaginal bleeding

Last GYN exam:_____
Last mammogram:_____
- ☐Other:_____

GU
- ☐Painful urination
- ☐Blood in urine
- ☐Urinate frequently
- ☐Difficulty starting stream
- ☐Other: _____

ENDOCRINE
- ☐Excessive thirst
- ☐Excessive urination
- ☐Significant weight gain/loss
- ☐Other:_____

NEURO
- ☐Memory problems
- ☐TIA
- ☐Stroke
- ☐Dizziness
- ☐Other: _____

PSYCHOLOGICAL
- ☐Inability to sleep
- ☐Panic attacks
- ☐Depression
- ☐Anxiety all the time
- ☐Inability to think
- ☐Other:_____

DERMATOLOGIC
- ☐Skin rash
- ☐Hair loss
- ☐Excessive itching
- ☐Change in skin color
- ☐Other: _____

MUSCULOSKELETAL
- ☐Joint swelling
- ☐Joint pain
- ☐Pain not relieved by rest
- ☐Spine pain
- ☐Other: _____

HEMATOLOGIC
- ☐Tired/Fatigue
- ☐Irregular bleeding
- ☐Easy bruising
- ☐History of blood clots/DVT/PE
- ☐Anemia
- ☐Other: _____

9. ADDITIONAL INFORMATION – Is there anything else you would like for your physician to be aware of?

_____

_____

_____

My signature below confirms that I have filled out this form to the best of my abilities as accurately as possible.

Patient/Guarantor Signature*_____ Date:_____